CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

**OFFICE OF CONTROLLED SUBSTANCES**

TELEPHONE: (302) 744-4500
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# APPLICATION FOR FACILITY CONTROLLED SUBSTANCES REGISTRATION

**For Office Use Only: DE License #**_____ **Office Approval** _____ **Inspection** _____

**INSTRUCTIONS**

A facility is required to have a Delaware controlled substances registration (CSR) when it will store controlled substances in Delaware or dispense/distribute controlled substances *to, in or out of* Delaware. If the facility is a pharmacy, hospital pharmacy, provider pharmacy, distributor or manufacturer, the facility must hold a Delaware professional license issued by the Board of Pharmacy before this CSR application will be processed. Clinics, research facilities and laboratories do not need a professional license from the Board of Pharmacy. If the facility needs but does not already have a Delaware professional license, you may apply concurrently for the professional license and CSR, or you may apply for the CSR later. To apply for a Delaware professional license, see the Board of Pharmacy Forms page.

☐ Submit a completed *Application for Facility Controlled Substances Registration*, signed by a representative of the facility in the presence of a notary.
☐ Enclose the required, non-refundable processing fee by check or money order made payable to '"State of Delaware."

In-state facilities where controlled substances are stored for patient administration will be inspected before the CSR is issued.

If the facility relocates or its ownership changes after a CSR is issued, you must reapply for a new registration.

## TYPE OF APPLICATION

1. Show whether you are applying for a new registration or reapplying (check one):
   ☐ Applying for a new or additional registration.
   ☐ *Reapplying* due to relocation. Enter current registration number: _____
   ☐ *Reapplying* due to change of ownership. Enter current registration number: _____

2. Check the type of registration you are applying for (check one): ☐ Pharmacy (PH) ☐ Hospital/Clinic (HC)
   ☐ Provider Pharmacy Facility (PF) ☐ Distributor/Manufacturer (*Including Reverse Distributors*) (DM)
   ☐ Research/Laboratory (RL)

3. Check the schedule(s) you are applying for: ☐ I ☐ II ☐ III ☐ IV ☐ V

4. Will controlled substances for patient administration be ***stored*** at this facility? Yes ☐ No ☐

5. Will controlled substances be ***dispensed*** at this facility? Yes ☐ No ☐

**If controlled substances will be dispensed, you must report ALL controlled substances that you dispense to the Delaware Prescription Monitoring Program (PMP). For instructions on registering for the PMP, see the Dispenser's Implementation Guide.**

## FACILITY IDENTIFYING AND CONTACT INFORMATION

6. Name: _____

7. ***Location* Address** (***no*** *PO Boxes*): _____
   Street

   _____ _____ _____
   City State Zip

8. Phone: _____ Email: _____

9. **Mailing Address** (*if different from physical location*): _____
Street

_____ _____ _____
City State Zip

10. Does the facility already have a Delaware professional license? Yes ☐ No ☐ **If yes, enter license number:** A ___ - _____

11. Federal DEA No: _____

**FACILITY OWNERSHIP AND MANAGEMENT INFORMATION**

12. What type of business is the applicant? (*Check one.*)

☐ Proprietorship ☐ Partnership ☐ Corporation – Enter state of incorporation: _____

☐ Other (specify): _____

13. List DEA registration numbers of all manufacturers, distributors, researchers or laboratories.

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14. Enter the following information about the person who has administrative or managerial responsibility for the location.

Name: _____

Address: _____

_____ _____ _____
City State Zip

Phone: _____ Email: _____

15. Enter the following information about the registered agent (*corporation*) upon whom orders may be served (*if non-resident proprietor or partner*).

Name: _____

Address: _____

_____ _____ _____
City State Zip

Phone: _____ Email: _____

16. Enter the following information about ***each*** proprietor, general partner, corporate officer (President, Secretary, Chief Executive Officer) and principal shareholder(s) (owner of 10% or more of outstanding common stock). *Attach additional sheets if necessary.*

| NAME | TITLE | RESIDENCE ADDRESS |
|---|---|---|
| | | |
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**DISCLOSURES**

17. Have any of the officers and owners of the facility who are listed in Question 16 or any pharmacists ever been convicted of a felony or misdemeanor under state or federal law relating to the manufacture, distribution or dispensing of controlled substances? Yes ☐ No ☐ **If yes, attach a letter explaining the circumstances of such action.**

18. Has any previous registration under the Controlled Substances Act (state or federal) held by the facility, corporation or firm or any officer or owner of the facility listed in Question 16 ever been surrendered, revoked, suspended, denied or is pending such action? Yes ☐ No ☐ **If yes, attach a letter explaining the circumstances of such action.**

19. Will the facility manufacture, distribute or conduct research in the individual controlled dangerous substances Schedules I and II? Yes ☐ No ☐ **If yes, list the applicable controlled dangerous substances below.**

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**To assure consideration of your registration application, the Office of Controlled Substances must receive all of these items:**

- **Completed, signed and notarized application form**
- **Fee payment**
- **All required supporting documentation.**

**Applications that are not <u>complete</u> within six months of filing may be considered abandoned and discarded.**

**Please note: When your application is <u>complete</u>, please allow 3-4 weeks to receive your license.**

## AFFIDAVIT

**I hereby certify that the facts stated in this application, including the statements on the attached schedule, are true, complete and correct and that application is made to obtain a biennial registration pursuant to the Uniform Controlled Substances Act.**

**I agree to abide to the laws of Delaware and the federal government.**

**Signature of Applicant**: _____ Date: _____

Printed Name: _____ Title: _____

State of: _____ County of: _____

Sworn to before me and subscribed in my presence this _____ day of _____, 2_____

Signature of Notary: _____

SEAL

My Commission expires: _____

***APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.***